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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of the annual Medicare re-certification survey in accordance with 42 CFR Chapter IV Part 483 - Requirements for States and Long Term Care Facilities, on 4/21/09 through 4/24/09. The census at the time of the survey was 108. The sample size was 22 including 3 closed records. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to provide proper privacy measures when performing medical treatment for one unsampled resident (#24).

Findings include:

Resident #24

Resident #24 was admitted on 4/19/09.

On 4/23/09 at 9:15 AM, Employee #10 entered Resident #24's room. Resident #24 was sitting in her wheelchair. Next to Resident #24, approximately 2 feet away, was her roommate who was also sitting in her wheelchair. The room window had the blinds fully open and had a view of the sidewalk and parking lot. Employee #10 entered the room and did not close the door behind her, did not draw the privacy curtain between the residents, and did not close the window blinds. Employee #10 lifted Resident #24's gown above her chest exposing both her breasts to check the feeding tube located on the abdominal area.

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F 164	Continued From page 2 On 4/24/09 in the afternoon, the Director of Nursing confirmed that privacy measures should have been implemented when providing treatment to a resident in a room, especially when the roommate is sitting next to the resident.	F 164		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that residents were cared for in an environment that maintained dignity for 2 of 22 residents (#6, #7). Findings include: Resident # 6 Resident #6 was a 69 year old male admitted to the facility on 3/21/09 with diagnoses including Seizures, Parkinson's Disease, Anemia, Muscle Weakness and Dementia. On 4/22/09 at 12:15 PM, Resident #6 was observed from the hallway, sitting in a wheelchair in his room with the bedside table in front of him. Resident #6 indicated he refused his lunch tray because he did not like the food that was offered. The charge nurse was notified. On 4/22/09 at 12:30 PM, Resident #6 was given a tray and started eating.	F 241		

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F 241	Continued From page 3 On 4/22/09 at 1:30 PM, Resident #6 was sitting in a wheelchair eating his lunch. Resident #6 was slumped over with his face almost touching the food on the tray. Resident #6 had a long apron that covered him and there was a large amount of food spilled on the apron. On 4/22/09 at 2:30 PM, Resident #6 was sitting in a wheelchair eating his lunch. Resident #6 was slumped over with his face almost touching the food on the tray. Resident #6 had a long apron that covered him and there was a large amount of food spilled on the apron. On 4/22/09 at 2:50 PM, Resident #6 was in the same position in his room still eating his lunch. On 4/22/09 at 3:00 PM, the charge nurse indicated that Resident #6 usually took a long time to eat. He was supposed to eat in the Resident Assisted Dining Room but he refused to go today. At no time was staff observed in Resident #6's room assisting him with his meal. On 4/22/09 at 3:25 PM, the CNA (Certified Nursing Assistant) changed Resident #6's clothes and removed the lunch tray. Resident # 7 Resident #7 was a 69 year old female admitted to the facility on 12/7/07 with diagnoses including Alzheimer's Disease, Chronic Renal Insufficiency, Aphasia, and Anemia.	F 241		

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F 241	Continued From page 4 The resident was bedbound, unable to communicate, totally dependent on the staff and received PEG (Percutaneous Endoscopic Gastrostomy) tube feedings. On 4/22/09 at 10:00 AM, Resident #7 was in bed lying on her back with her eyes open. There were no staff in the room and no TV on. The bedside curtain was pulled the length of the bed and Resident #6 was not visible from the hallway. On 4/22/09 at 12:00 PM, 2:00 PM, and 4:00 PM, observed Resident # 7 in her room lying in bed with the bedside curtain pulled so the resident was not visible from the hallway. There were no staff or visitors in the room. On 4/23/09 at 10:40 AM, Resident # 7 was in her room lying in bed with the bedside curtain pulled so the resident was not visible from the hallway. There were no staff or visitors in the room. On 4/23/09 in the morning, the DON (Director of Nursing) indicated she did not know why Resident #7's curtain was pulled. She indicated usually the curtain remained open unless the resident was receiving care or had visitors. The DON also indicated she did not know why the resident remained bedbound.	F 241		
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to accommodate the needs of 2 of 22 residents (#17, #7).

Findings include:

Resident #17

Resident #17 was admitted 3/13/09 with diagnoses including Trauma Fracture Low (lower) Leg (right Distal Tibia and Fibula Fractures), Difficulty in Walking, Muscle Weakness-general, Diabetes Mellitus II, Morbid Obesity, Hyperosmolality, Hypertension, Arteriosclerotic Cardiovascular Disease, Amputation of toe, Aortocoronary Bypass, Neuropathy in Diabetes.

On 4/22/09 and 4/23/09, Resident #17 indicated she would like to have her toenails cut and that she had repeatedly asked for podiatry care since she was admitted. Resident #17's toenails were observed to be long, yellow, and not maintained, with dirt and grime underneath.

On 4/24/09, the Assistant Director of Nursing indicated she was not aware whether the facility had requested podiatry services for Resident #17. The Administrator provided a list with the resident's name ("Podiatry List", undated) and indicated that the resident's name had been placed on the list at some date within the previous 2 weeks, but that the Podiatrist had not been able to provide services as of 4/24/09.

There was no documented evidence of a written plan of care addressing Resident #17's provision

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F 246	Continued From page 6 of nail care. Resident # 7 Resident #7 was a 69 year old female admitted to the facility on 12/7/07 with diagnoses including Alzheimer's disease, Chronic Renal Insufficiency, Aphasia, and Anemia. The resident was bedbound, unable to communicate, totally dependent on the staff and received PEG (Percutaneous Endoscopic Gastrostomy) tube feedings. On 4/22/09 at 10:00 AM, Resident #7 was lying in bed on her back. Both hands were contracted without hand rolls in place. Resident #7's left thumbnail was very thick, yellow, bent over backwards and approximately 1 inch long. On 4/24/09, the DON (Director of Nursing) indicated that nail care on residents' hands was provided by the nursing staff. There was no documented evidence that nail care was provided for Resident #7.	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

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The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure care plans were updated and interventions were followed for 2 of 22 residents (#1, #6).

Resident #1

Resident #1 was an 84 year old female admitted to the facility on 2/2/09 with diagnoses including Cerebral Vascular Accident, Spinal Stenosis, Laminectomy, Hypothyroidism, Hypertension and Stage IV Sacral Decubitus.

The Initial Fall Risk Assessment dated 2/2/09 revealed Resident #1 scored 14, which indicated the resident was a high risk for falls.

Nurse's notes revealed:
-2/5/09 at 11:00 AM "Pt (patient) found on the floor lying on her back next to her bed..."
-2/6/09 "IDT (Interdisciplinary Team) met to discuss resident rolled out of bed (on air mattress) SR (Siderails) up x2...Assisted back to bed...SR's up x4..."

The Care Plan dated 2/10/09 for Falls indicated

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the following interventions:
- ..."Apply personal alarm as ordered"
-..."PT (Physical Therapy), OT (Occupational Therapy) eval (evaluation) and tx (treatment)"

The Nurse's notes dated 4/2/09 revealed "Resident found bent over on her knees in front of her dresser with bleeding puncture wound to (r) (right) temple...."

The care plan updated on 4/2/09 included the following interventions:
-"PSA (Personal Safety Alarm) at all X's (times)
- Mattress Alarm
- Bed low with mats"

On 4/21/09 at 12:00 PM, observed Resident #1 lying in bed on her back. The bed was not in a low position, there were no mats on the floor and siderails were up on the upper half of the bed.

On 4/21/09 at 4:15 PM, observed Resident # 1 lying in bed on her right side. The bed was not in a low position, there were no mats on the floor and all 4 siderails were up.

On 4/21/09 at 4:45 PM, the charge nurse indicated that all 4 siderails were up due to Resident #1's history of falls.

There was no documented evidence of a physician order for all 4 siderails to be up.

On 4/22/09 in the morning, Resident #1's bed was observed in a low position and mats were placed on the floor on both sides of the bed.

On 4/22/09 in the morning, Employee # 6 indicated the low bed and mats had previously

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F 279	Continued From page 9 been on Resident #1's care plan, but had not been initiated. Resident #6 Resident #6 was a 69 year old male admitted to the facility on 3/21/09 with diagnoses including Seizures, Parkinson's Disease, Anemia, Muscle Weakness and Dementia. Nurse's notes dated 4/7/09 revealed: - 11:30 AM - " Resident possibly with seizure activity when being seen by ST (Speech Therapy) services." - 13:40 (1:40 PM) - "Resident noted to have another seizure (tonic/clonic)." Resident #6's care plan dated 3/28/09 indicated: -"...4. Pad siderails if indicated by multiple seizures or high potential for injury." On 4/21/09 and 4/22/09, on several occasions each day, observed Resident #6 sitting in a wheelchair in his room. There were no padded siderails noted on the resident's bed. On 4/23/09 in the morning, observed padded siderails on Resident #6's bed.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the facility failed to ensure 2 of 22 residents received necessary care in accordance with the physician's orders (#17, #6). Findings include: Resident #17 Resident #17 was admitted 3/13/09 with diagnoses including Trauma Fracture Low (lower) Leg (Right Distal Tibia and Fibula Fractures), Difficulty in Walking, Muscle Weakness-general, Diabetes Mellitus II, Morbid Obesity, Hyperosmolality, Hypertension, Arteriosclerotic Cardiovascular Disease, Amputation of Toe, Aortocoronary Bypass, Neuropathy in Diabetes. The medication recapitulation for March and April of 2009 indicated the following physician's orders: Accucheck AC (before meals) and HS (hour of sleep), Novolog for Sliding Scale - Call if < (less than) 60 and > (greater than) 300: 80-120=2 Units 121-150=3 Units 151-180=4 Units 181-200=5 Units 201-230=6 Units 231-260=7 Units 261-290=8 Units 291-350=9 Units 351-400=10 Units The Sliding Scale Insulin Administration Record for the months of March and April of 2009	F 309		

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included the above sliding scale orders, and further stated, "Call MD (Medical Doctor) if BS (Blood Sugar) < 60." The Administration Record listed blood sugar reading times as 06:30 (6:30 AM), 11:30 (11:30 AM), 1630 (4:30 PM), and 2030 (8:30 PM). The Administration Record for April of 2009 did not include the physician's orders to call the MD if the blood sugar was more than 300.

The Sliding Scale Insulin Administration Record for March and April of 2009 indicated inconsistencies with the physician's orders regarding blood sugar readings and sliding scale insulin administration for the following dates:

3/15/09: 6:30 AM, reading of 248, results: insulin entry "Held." (There was no documented information regarding why the insulin was not administered in the Nurses' Medication Notes.)

3/16/09: 6:30 AM, reading of 136, blank entry regarding insulin administration units.
4:30 PM, reading of 201, blank entry regarding insulin administration units.
8:30 PM, reading of 302 (There was no documented evidence that the facility contacted the physician.).

3/17/09: 6:30 AM, reading of 101, blank entry regarding insulin administration units.
4:30 PM, reading of 365. (There was no documented evidence that the facility contacted the physician.).

3/18/09: 8:30 PM, reading of 325. (There was no documented evidence that the facility contacted the physician.).

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F 309	Continued From page 12 3/19/09: 6:30 AM, reading of 128, administration of only 2 units of insulin. 4:30 PM, no documentation that the resident's blood sugar was checked, and a blank entry regarding any insulin administration units. 3/21/09: 6:30 AM, reading of 114, insulin entry "Held." (There was no documented information regarding why the insulin was not administered in the Nurses' Medication Notes.) 3/24/09: 6:30 AM, reading of 113, blank entry regarding insulin administration units. 11:30 AM, reading of 148, blank entry regarding insulin administration units. 4:30 PM, reading of 216, blank entry regarding insulin administration units. 3/25/09: 6:30 AM, reading of 113, blank entry regarding insulin administration units. 11:30 AM, reading "0", insulin administration units, "0". 4:30 PM, reading of 98, blank entry regarding insulin administration units. 8:30 PM, reading of 353. (There was no documented evidence that the facility contacted the physician.). 3/31/09: 6:30 AM, reading of 126, only 2 units of insulin administered. 11:30 AM, reading of 125, only 2 units of insulin administered. 4/2/09: 6:30 AM, reading of 114, blank entry regarding insulin administration units. 11:30 AM, reading of 200, units of insulin administered (illegible). 4:30 PM, reading of 280, but 9 units of insulin administered.	F 309		

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F 309	Continued From page 13 4/4/09: 6:30 AM, reading of 127, 0 units of insulin administered. 4:30 PM, reading of 300, only 8 units of insulin administered. 4/5/09: 6:30 AM, reading of 112, 0 units of insulin administered. 4:30 PM, reading of 120, 0 units of insulin administered. 4/6/09: 6:30 AM, reading of 97, 0 units of insulin administered. 4/7/09: 6:30 AM, reading of 96, 0 units of insulin administered. 4/10/09: 6:30 AM, reading of 117, 0 units of insulin administered. 4/12/09: 6:30 AM, reading of 107, blank entry regarding units of insulin administered. 4/13/09: 6:30 AM, reading of 100, 0 units of insulin administered. 4/14/09: 6:30 AM, reading of 113, 0 units of insulin administered. 4/15/09: 6:30 AM, reading of 134, only 2 units of insulin administered. 4/16/09: 11:30 AM, reading of 100, 0 units of insulin administered. 4:30 PM, reading of 280, illegible units of insulin administered. 4/18/09: 8:30 PM, reading of 200, blank entry regarding units of insulin administered.	F 309		

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4/19/09: 4:30 PM, reading of 294, only 8 units of insulin administered.

Resident #6

Resident #6 was a 69 year old male admitted to the facility on 3/21/09 with diagnoses including Seizures, Parkinson's Disease, Anemia, Muscle Weakness and Dementia.

Physician's orders revealed:
-3/24/09 - "Depakote 250 mg (milligrams) Liquid po (by mouth) three times a day-Seizure Disorder."
-4/4/09 - "Depakote 250 mg po tablet three times a day."
-4/16/09 - "Increase Depakote to 300 mg (milligrams)."
-4/21/09 - "Clarification of order: Give Depakote liquid 300 mg (6 ml) (milliliters) orally three times a day."

Laboratory results revealed Valproic Acid (Depakote) level:

Date	Level	Normal
3/27/09	27.7	50-100
4/7/09	39.3	
4/14/09	41.8	

The Medication Administration Record (MAR) dated April 2009 revealed:
-Depakote 250 mg was discontinued on 4/16/09
-Depakote 300 mg was started on 4/19/09
-There was no documented evidence that Resident #6 received Depakote on 4/17/09 and 4/18/09.

On 4/23/09 in the afternoon, the LPN (Licensed

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F 309	Continued From page 15 Practical Nurse) confirmed Resident #6 did not receive Depakote on 4/17/09 and 4/18/09 according to documentation on the MAR.	F 309		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assess the need for an indwelling catheter for 1 of 22 residents (#19). Findings include: Resident #19 Resident #19 was admitted on 4/20/09 with diagnoses including Congestive Heart Failure, Depression, Non Hodgkin's Lymphoma, Benign Prostatic Hypertrophy (BPH), and Diabetes. Resident #19 was observed in his room on 4/23/09 and 4/24/09 with a patent catheter bag hanging on the side of his wheelchair. The Physician Admission Orders form dated 4/20/09 on section 14 ordered an indwelling catheter with no documented reason.	F 315		

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F 315	Continued From page 16 Resident #19's Catheter Justification Worksheet documented: -"...When attempting to remove indwelling catheter institute voiding trial: Step 1 - Record urine output from catheter drainage bag every 6 hours for 2 days. (Purpose is to determine approximately when 800cc (cubic centimeters) of urine has been produced as this is the approximate capacity of the bladder. If the resident has not voided within the expected time reinsert the catheter.) Step 2 - Obtain physician order; remove indwelling catheter and continue to record output. Step 3 - Resident is able to void, check post-void residual - have resident void and then straight cath. (catheterize) within 15 minutes after voiding..." -"...If volume > (greater than) 400cc, reinsert indwelling catheter notify physician and responsible party..." -"... If PVR (post void residual) is 100 - 400cc, observe carefully for retention over next few days to few weeks..." -"...If resident has sensation, can respond to urge, voids without prompting, assist to toilet as needed..." -"...If resident has not voided by the time the expected volume is 800cc, there is no sensation of fullness, reinsert catheter, notify physician and notify responsible party..."	F 315		

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F 315	Continued From page 17 -"...If resident is incontinent and has zero residual or if residual is < (less than) 400cc do Assessment for Bowel and Bladder Training and begin process..." The reason documented on the form why removal of the indwelling catheter was not attempted was due to BPH. There was no documented evidence Resident #19 had a history of urinary retention. There was no documented evidence attempts were made to remove the indwelling catheter or no PVR's were performed. An Assessment for Bowel and Bladder Training form was completed for Resident #19 on 4/20/09. The total score was 6 which revealed Resident #19 was a good candidate for individual training. On 4/24/09 at 10:45 am, Resident #19's daughter was contacted by phone by the surveyor. The daughter indicated her father had never used an indwelling catheter until he arrived at the facility. The daughter indicated her father had no problems urinating but had fallen because he gets up several times to use the bathroom. The daughter indicated she was able to attend a meeting two days prior with the staff to discuss the care. She indicated she was told by the staff that there was no reason for the indwelling catheter and it may be discontinued. The daughter was informed of the side effects of having an indwelling catheter but thought the catheter was being used for convenience due to her father falling when he got up to go to the bathroom. She indicated she was not informed about other alternatives such as using a urinal, condom catheter or implementing a bladder training program.	F 315		

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F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a medication error rate less than 5%. Findings include: Error Rate: Fifty one medication passes were observed. There were 4 errors for a medication error rate of 7.8%. Resident # 20 Resident #20 was a 69 year old female admitted to the facility on 4/20/09 with diagnoses including Parkinson's disease, Chronic Back Pain, Hypothyroidism, and Anxiety. On 4/22/09 observed Employee #11 administering routine 8:00 AM medications to Resident #20. Employee #11 poured Sinemet 25/100 1 tablet to administer to Resident #20. Before the Sinemet was administered, Employee #11 was stopped by the surveyor and asked to recheck the medication. The Medication Administration Record (MAR) dated April 2009, revealed that Sinemet 25/100 was given at 6:00 AM. Employee #11 indicated that although it was signed for at 6:00 AM, the medication was usually given at 8:00 AM.	F 332		

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Employee #11 asked the resident if she received the Sinemet at 6:00 AM and the resident indicated she did not receive any medications.

Employee #11 did not administer the medication and indicated she would confirm with the night nurse whether the Sinemet was given.

Physician's orders dated 4/20/09 indicated "Sinemet 25/100 one tablet q8h (every eight hours) for Parkinson".

On 4/22/09 in the afternoon, the DON (Director of Nursing) stated she had confirmed with the night nurse that the Sinemet 25/100 was administered at 6:00 AM as signed.

Resident # 25

Resident #25 was an 83 year old male admitted to the facility on 3/26/09 with diagnoses including Diabetes and Respiratory Difficulties.

On 4/22/09 observed Employee #12 administering routine 8:00 AM medications to Resident #21. Employee #12 provided Resident #25 with an Advair Inhalant. She did not instruct the resident how many puffs the resident should take.

Resident #25 took 2 puffs of Advair 250/150.

The Physician's Order dated 3/21/09 indicated "Advair 250/150 1 puff bid (twice a day)."

Employee #12 indicated she did not see how many puffs Resident #25 inhaled.

Resident #23

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F 332	Continued From page 20 Resident #23 was admitted on 9/18/08, and readmitted on 4/1/09, with diagnoses including Grand Mal Status, Iron Deficiency, Paralysis, and Depressive Disorder. On 4/22/09 at 7:00 AM, Employee #9 was preparing Resident #23's morning medications. Employee #9 obtained a packaged tablet labeled Omeprazole 20 mg (milligrams) from the medication cart. Employee #9 indicated Protonix was discontinued (d/c) and Prilosec was started for Resident #23. Employee #9 then wrote d/c on the Omeprazole package and placed the package back into the medication cart. Employee #9 indicated the pharmacy would be notified about the missing Prilosec medication. Resident #23's physician orders dated 4/11/09 ordered to discontinue Protonix and start Prilosec 20 mg every day. On 4/22/09 at 1:45 PM, Employee #9 indicated the Omeprazole package was thrown away and Prilosec was not given to Resident #23. Employee #9 did not clarify the indications for use and generic name of Omeprazole. According to the drug information handbook, Prilosec was the Brand Name and Omeprazole was the Generic Name (According to the Physician's Desk Reference). The unit charge nurse indicated if the staff had any questions about medications, a drug information handbook was available at the nursing station. Resident #24 Resident #24 was admitted on 4/19/09.	F 332		

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F 332	Continued From page 21 On 4/23/09 at 9:15 am, Employee #10 administered two 250 mg tablets of calcium plus vitamin D to Resident #24. The physician's admission orders dated 4/19/09 indicated 500 mg of calcium. There was no documented evidence vitamin D was ordered with the calcium. On 4/23/09 in the afternoon, Employee #10 confirmed calcium with no vitamin D should have been administered.	F 332		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered accurately for 1 of 22 residents (#6). Findings include: Resident #6 Resident #6 was a 69 year old male admitted to the facility on 3/21/09 with diagnoses including Seizures, Parkinson's disease, Anemia, Muscle Weakness and Dementia. Nurse's notes dated 4/7/09 revealed: - 11:30 AM - " Resident possibly with seizure activity when being seen by ST (Speech Therapy) services." - 13:40 (1:40 PM) - "Resident noted to have another seizure (tonic/clonic)."	F 333		

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F 333	Continued From page 22 Laboratory results revealed Valproic Acid (Depakote) level: Date Level Normal 3/27/09 27.7 50-100 4/07/09 39.3 4/14/09 41.8 Physician's orders revealed: -3/24/09 - "Depakote 250 mg (milligrams) Liquid po (by mouth) three times a day- Seizure Disorder." -4/4/09 - "Depakote 250 mg po tablet three times a day. -4/16/09 - "Increase Depakote to 300 mg (milligrams)." -4/21/09 - "Clarification of order: Give Depakote liquid 300 mg (6 ml) (milliliters) orally three times a day." The Medication Administration Record (MAR) dated April 2009 revealed: -Depakote 250 mg was discontinued on 4/16/09 -Depakote 300 mg was started on 4/19/09 -There was no documented evidence that Resident #6 received Depakote on 4/17/09 and 4/18/09. On 4/23/09 in the afternoon, the LPN (Licensed Practical Nurse) confirmed Resident #6 did not receive Depakote on 4/17/09 and 4/18/09 according to documentation on the MAR.	F 333		
F 369 SS=D	483.35(g) DIETARY SERVICES - ASSISTIVE DEVICES The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced	F 369		

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by:
Based on observation, interview, and record review, the facility failed to ensure assistive devices were available for 1 of 22 residents (#6).

Findings include:

Resident #6

Resident #6 was a 69 year old male admitted to the facility on 3/21/09 with diagnoses including Seizures, Parkinson's disease, Anemia, Muscle Weakness and Dementia.

Resident #6's care plan dated 3/24/09 stated, "...tipped plate to be used for all meals daily."

Physician's orders dated 4/7/09 indicated "Pt (Patient) to use weighted utensils at all meals to facilitate self feeding."

On 4/22/09 at 12:30 PM, Resident #6 was sitting in a wheelchair in his room feeding himself lunch. The resident was using weighted utensils but did not have a tipped plate.

The resident was observed with a large amount of food spilled on his apron.

On 4/23/09 at 7:45 AM, Resident #6 was sitting in the RA (Resident Assisted) dining room. He did not have weighted utensils or a tipped plate. Resident #6 began feeding himself by hand and with a soup spoon. He appeared to be having difficulty and spilled a large amount of his cereal on his clothing protector.

On 4/23/09 at 7:50 AM, Employee #13 requested a special mug for Resident #6. The mug was

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F 369	Continued From page 24 never received during the breakfast meal. On 4/23/09 at 8:10 AM, Employee #13 indicated she was aware that Resident #6 required special weighted silverware and a special plastic mug. She indicated the weighted silverware was sometimes sent to the resident's room and she would try to locate it. Employee #13 added Resident #6 sometimes asked for a soup spoon and ate quite well using that utensil. She also indicated that the coffee mug usually worked as well as the plastic mug.	F 369		
F 371 SS=D	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility failed to ensure 2 kitchen employees wore hair coverings. Findings include: Observation On 3/23/09 during observation of the lunch meal from approximately 11:20 until 12:15 PM, there were 2 employees who were not wearing hair	F 371		

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F 371	Continued From page 25 nets or other coverings. The employee who was dishing out food from the steam tables had a hair net on, however, it covered only her head and did not cover the ponytail. One of the 2 employees who was preparing and arranging the food trays did not have a hair covering. Document Review The Policy and Procedure, revision date 01/01/2007, stated: "Policy: All associates follow the defined company code of conduct and conduct themselves in a courteous and professional manner at all times. Guidelines: Associates present a neat and clean appearance at all times. The Food and Nutrition Services associates wear a hair covering, which covers all unpinned hair at all times..."	F 371		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		

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F 431	Continued From page 26 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to store drugs and biologicals under proper conditions. Findings include: The Facility's policy and procedure labeled Medication Storage and Security in the Facility had a revised date of 6/06. Page 12-23 documented: -"...Medications requiring "refrigeration" or "temperatures between 2 degrees C (Celsius) (36 degrees Fahrenheit) and 8 degrees C (46 F)" are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications that require storage "in a cool place" are refrigerated unless otherwise directed on the label..." On 4/22/09 in the morning, the 100/200 unit medication room refrigerator thermometer read	F 431		

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32 degrees Fahrenheit (F). The surveyor's thermometer was left in the refrigerator for 15 minutes and also read 32 degrees F. Stored in the refrigerator were several vials and containers of medication including vials of Insulin, Tuberculin, and intravenous bags of Vancomycin.

The Record of Refrigeration Temperature form dated March 2009 documented on March 19, the refrigerator temperature was 34 degrees F. All other entries recorded in March of 2009 had freezing (32 degrees Fahrenheit) or below freezing temperatures ranging from 28 to 32 degrees F.

The Record of Refrigeration Temperature form dated April 2009 had freezing or below freezing temperatures recorded 16 out of 22 days. On 4/22/09 the refrigerator temperature recorded was 28 degrees F.

On 4/22/09 in the morning, the unit charge nurse indicated she was not informed by the staff about the freezing refrigerator temperatures.
On 4/22/09 at 1:45 PM, the Medication Room on the 300 Hall contained the following:
In the cabinet:
- Chemstrip 10 MD - 100 urine test strips, Lot # 2898441; Expiration Date - 08/2008

In the refrigerator:
- Droperidol 25's P/F 2.5 mg/ml (milligram per milliliter), 5 vials, lot # 6644, Expiration date 09/2008

Employee #12 confirmed the expiration dates and indicated that the Droperidol vials were from a resident who had been discharged. She added usually medications for discharged residents were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295076	A. BUILDING _____ B. WING _____	04/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENT-PARADISE VALLEY	2325 E. HARMON AVE. LAS VEGAS, NV 89119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 28 sent back to the pharmacy, but she did not know why these were not returned.	F 431		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain and practice infection control measures to ensure the prevention of transmission of any diseases and infection. Findings include: 1. On 4/24/09 at 9:20 AM, an attended thermal cooler on a wheeled cart used to distribute ice to the residents was in the 200 hallway. Upon opening the cooler, the ice scoop was observed lying directly on the ice. A certified nursing assistant (CNA) indicated the scoop should not be stored inside the cooler. The CNA indicated the scoop should be stored inside the scoop holder beside the cooler. 2. On 4/24/09 at 10:15 AM, located in the therapy room were 2 containers filled with putty used for rehabilitation exercises. The small container was	F 441		

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F 441	Continued From page 29 not labeled and not dated when it was opened. The small container was left open and the putty was oozing out of the container and sticking on other equipment. The large container was labeled Theraputy and not dated when it was opened. The large container was not oozing out of the container. Embedded in the putty of the large container were particles of dirt and several strands of body hair. The Director of Rehabilitation Services indicated the putty was probably not anti-bacterial putty and was used from resident to resident except residents who had open sores. The Director of Rehabilitation indicated there was no policy regarding the use of the putty.	F 441		
F 442 SS=D	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, the facility failed to isolate 2 of 24 sample residents according to the facility's infection control program (#15 and #21). Findings include: Resident #15 Resident #15 was admitted to the facility on 4/2/09, with a diagnosis of Methicillin Resistant Staphylococci Aureus (MRSA) of the nares.	F 442		

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F 442	Continued From page 30	F 442		

Resident#15's care plan dated 4/10/09 indicated "Contact Isolation".

The facility policy titled Contact Precautions, dated 5/21/04 revealed:
"Resident Placement:
-The resident may be placed in a private room. If a private room is not needed/not available, the resident may be placed in a room with a resident(s) who has active infection with the same organism but with no other infection."

On the morning of 4/21/09, Resident #15 and Resident #21 were observed residing in the same room.

Resident #21

Resident #21 was admitted to the facility on 4/3/09, with a diagnosis of Vancomycin Resistant Enterococcus (VRE) urinary tract infection.

The facility policy titled Vancomycin Resistant Enterococcus (VRE), last revised 5/8/08 indicated:
-"A VRE infected or colonized resident should be in a private room, if possible, or in a room with a resident who is colonized or infected with the same organism but does not have any other infection (cohorting) or placed with a resident who does not have risk factors for infection."

Resident #15 and Resident #21 were cohorting in the same room from 4/16/09 to 4/22/09, until Resident #21 was transferred to an acute care facility.

The Assistant Director of Nursing indicated in an interview on the morning of 4/24/09, that Resident

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F 442	Continued From page 31 #15 and Resident #21 were placed in the same room because Resident #15's MRSA of Nares was clearing. However, there was no physician's order to take either resident off isolation until 4/21/09 when the physician cleared Resident #15 from isolation.	F 442		